HSA Employee Nursing Scholarship Application

Important Information:

- ***Applications are Accepted February 1 – March 31st; 5:00 p.m.***
- ***Send completed application to Stanislaus Health Foundation, P.O. Box 302, Modesto, CA 95353 · Fax (209) 558-8320***
- ***All applicants shall be notified of the committee's decision no later than May 14th.***

PLEASE TELL US ABOUT YOURSELF **(Please print or type)**

Name: _____
First Name Middle Name Last Name

Telephone Number ___(___)_____ ___(___)_____
Home Cell

Address: _____ _____
Home Address Apt. No. City State Zip

WHY ARE YOU APPLYING FOR THIS SCHOLARSHIP?

Please tell us: Your educational goals and your current GPA. Append more pages if required.

I certify that all of the information I have given above is accurate to the best of my knowledge. I understand that if I am awarded a scholarship and do not attend the class(s), I must return the scholarship money to the Stanislaus Health Foundation.

Employee Signature: _____ Date: _____

APPROVAL OF DEPARTMENT MANAGER

I have read this application and, based on this employee's performance and work evaluation, I recommend that the Stanislaus Health Foundation consider him/her for this scholarship.

_____ Date: _____
Signature and Title

DISPOSITION OF REQUEST (completed by Scholarship Committee)

Request Approved ☐ Amount Approved $ _____ Request Denied ☐

_____ Date: _____
Signature of Scholarship Chairperson